

MARYLAND HEALTH CARE COMMISSION

UPDATE OF ACTIVITIES

April 2005

DATA SYSTEMS & ANALYSIS

Maryland Trauma Physician Services Fund

Last month the Office of the Comptroller issued checks to applicants approved for payment from the Fund during the first period in 2005. During the first application period, MHCC processed approximately 6,072 medical and 560 anesthesia services applications. Medical services increased by roughly 53.9 percent and the anesthesia services increased by about 71.9 percent during the first application period. Overall, the number of uncompensated care applications submitted during the first period in FY 2005 increased by roughly 44.2 percent from the prior period.

Staff completed a post payment review of uncompensated care applications submitted to the Fund during the first period in 2005. Patients listed on the uncompensated care applications were compared to the Maryland Institute for Emergency Medical Services Systems ("MIEMSS") Trauma Registry. Staff identified about eight patients out of 2,702 that were not listed on the MIEMSS Trauma Registry. These differences were reviewed with MIEMSS where it was determined that these patients were late entrees on the Trauma Registry and would appear next month. MHCC conducts a post payment review at the conclusion of each payment cycle.

Staff finalized the Trauma Fund operations procedure manual which can be used to train employees or can be used by an auditor conducting an internal review. The procedure manual details steps used to process uncompensated care, on-call, and stand-by (Children's National Medical Center) applications. Other uses for the procedure manual include report generating, and describing steps for storing and retrieving information from the MHCC network. Generally speaking, the procedure manual enables users to complete a variety of tasks associated with managing the Trauma Fund operations.

During the month staff completed development of the auditing request for proposal (RFP). The auditing contract awarded to Clifton-Gunderson, LLP expires at the end of June 2005. The original contract was for a fifteen month period and did not contain any renewal options. The current RFP includes renewal options that can extend the contract for up to five years. Staff anticipates releasing the auditing RFP in May and awarding the contract by June 30th.

Data Base and Application Development

Medical Care Data Base (MCDB)

Staff contacted payers that are required to submit data this June. Information specific to each company's previous 2003 Medical Care Data Base submission was e-mailed along with the current 2004 Data Submission Manual. Individual company information included quality reviews of the layout elements submitted last year for the encounter, pharmacy, and provider directory files. Payers were also e-mailed a spreadsheet showing total number of recipients, services, and payments for calendar years 2002 and 2003 by delivery system, plan type, and coverage type. The Commission requested that carriers verify their internal records with the totals listed on the

spreadsheet and provide documentation with this year's data explaining fluctuations over or fewer than ten percent.

Two additional data elements have been added to the 2004 submission requirements. A data field was added that identifies whether the practitioner services or prescription drugs were provided under a consumer-directed health plan (CDHP). As MHCC expects the CDHP products to grow in popularity, the new information will serve as a means to track future growth trends. Second, payers will be required to flag prescriptions supplied through a mail-order pharmacy. This new information will be used to support a study on mail-order for maintenance drugs required under SB 885, 'Maintenance Drug Prescriptions - Mail Order Purchase – Study'. That report is due in December 2005.

Internet-Based MHCC Assessment

Most nursing homes and payers submitted the financial information needed for computing the MHCC annual assessment. The new site has streamlined submission of financial data and increased efficiency of the MHCC staff by eliminating redundant entry of the paper forms. However, some nursing homes and payers have encountered problems using the site. We believe that most of the problems are related to the use of an out-of-date web browser, lack of reliable connection to the Internet, or apparent incompatibilities among the several servers used to handle address issues. Table 1 shows the filing status for the 1,150 organizations that are required to pay MHCC assessments.

Table 1 – MHCC ASSESSMENT SURVEY

Date: 4/11/2005

Web Tracking		
No. of Companies /Facilities	Insurance	Nursing Homes
Number	908	257
No Survey Required	6	12
Survey Required	902	245
Completion of Required Surveys		
Completed	732	194
Not Completed	170	51

Ambulatory Surgical Survey

Last month staff notified 317 ambulatory surgical centers (centers) required to complete the 2004 Freestanding Ambulatory Surgery Survey. As of the end of March, about ten percent of the centers completed the online survey. During the month, staff assisted about twenty centers in completing the survey. Staff anticipates the remaining centers will complete the survey within the forty-five day time frame.

Long Term Care Survey

The staff is planning for a July 1st release of the 2004 Long Term Care Survey. This is the third year that MHCC will collect the data via a Web application. This survey is used for nursing home bed need estimates, nursing home utilization studies, and for the MHCC Nursing Home

Quality Measurement Guide. The survey is easy to complete and will be used in conjunction with federal data sources to provide data for studies that the Commission is mandated to conduct.

Cost and Quality Analysis

Prescription Drug Use and Expenditures: Trends Among Privately Insured Patients

The MHCC will release its first prescription drug spending report at the April meeting. The report tracks growth in utilization of prescription drugs overall, by age and gender, and by type of insurance coverage in 2003. The report highlights the growing importance of prescription drug spending which in 2003 accounted for about 13 percent of total spending. Branded drugs account for about 55 percent of prescriptions and over 80 percent of the expense. The distribution of branded and generic did not change significantly from 2002 to 2004. The report confirms recent growth in patient cost sharing. In 2003, the typical patient paid approximately 36 percent of the annual drug spending. However, as spending increases, the patient share of spending declines; for example at the 75 percentile of annual spending the patient share is 30 percent, and at the 95th percentile the patient share is around 23 percent.

The report provides a more detailed look at utilization of several classes of drugs that have been heavily marketed via direct to consumer advertising. COX-2 inhibitors are a class of nonsteroidal anti-inflammatory drugs (NSAIDs) marketed for their protection against side effects common to most NSAIDs, in particular gastrointestinal bleeding. Use of COX-2 inhibitors has grown dramatically over the past nine months since their introduction in 1999. Two of the three leading COX-2 inhibitors have been pulled from the market due to a number of safety concerns. This report examines growth in COX-2 from 2002 to 2003 and compares expense of the COX-2 with other NSAIDs for treatment of acute and chronic pain. A subgroup of antidepressants -- Selective Serotonin Reuptake Inhibitors, or SSRIs, are given particular attention because of their overall influence in the rising use of this class of medicines among children. As with all antidepressants, use has been accompanied by adverse clinical outcomes. In this case, there is evidence that children treated with antidepressants may be at increased risk for suicidal thinking and behavior.

Privately Insured Maryland Children with Conditions Related to Being Overweight: Characteristics, Services, and Spending

The Centers for Disease Control and Prevention (CDC) has reported on the need to raise awareness about the growing obesity in the American population. Several MHCC commissioners have requested that MHCC staff use our data sources to examine the obesity in children. The analysis examines use of practitioner services by children age 6-19 that could be classified as possibly obese or overweight based on the ICD-9-CM diagnosis codes found on the practitioner claim. The study determined that about 2.5 percent of children insured through privately insured plans in the age 6-19 category had an overweight related diagnosis. This compares with survey data showing that about 16 percent of children in the category are overweight or obese. Annual per person practitioner health care payments for children in the obese-overweight group were \$880, unadjusted for differences in age, sex, plan, and other health conditions. These payments were almost twice as large as the unadjusted average annual payment for other children (\$456). However, only about 18 percent of the total expense could be tied to conditions used to identify the population. A statistical model was developed to estimate the additional costs associated with an obese or overweight condition in the non-HMO children population. Controlling for differences due to sex, insurer, and other medical conditions, predicted annual payments to practitioners are \$692 for children with an overweight-related condition, and \$400 for other children, but without such a condition—a difference of over 70 percent. The report also raises several caveats for this limited study. Additional study over time and including different

populations could help with efforts to further understand drivers of health care costs related to being overweight.

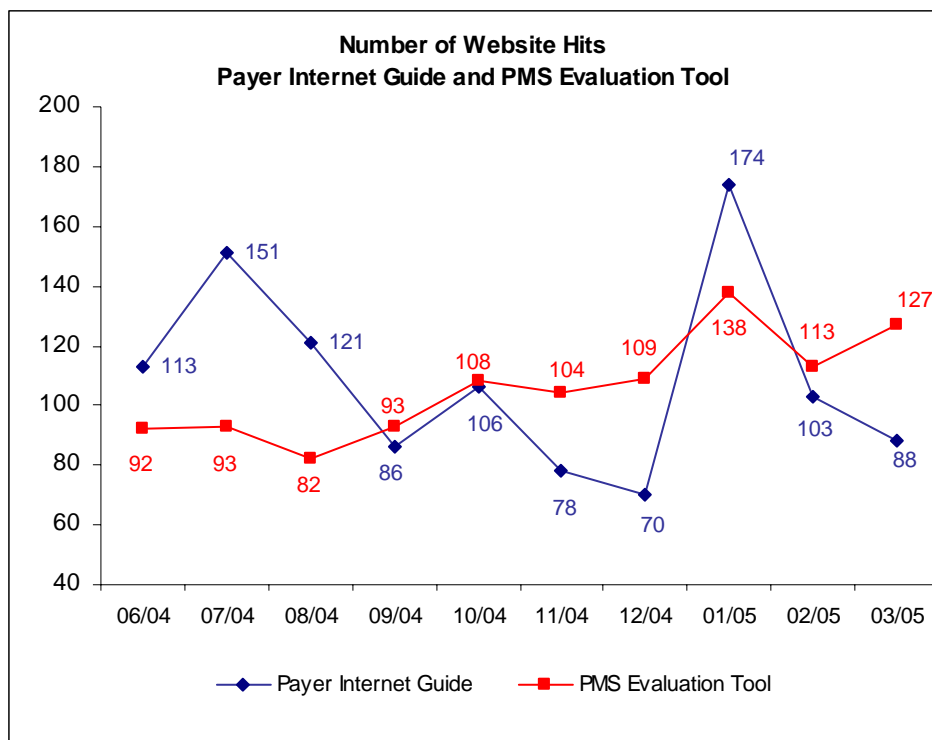
EDI Programs and Payer Compliance

EDI Initiatives

Staff formed a sub-group from the EDI/HIPAA Workgroup (Workgroup) to develop recommendations on initiatives aimed at educating providers on electronic medical records (EMR). The sub-group plans to meet in April and will present its recommendations to the Workgroup at the May meeting. The Workgroup will use recommendations put forth by the sub-group to develop provider EMR education and awareness initiatives.

During the month, staff finalized updates to the Payer Internet Guide with amendments to payers' provider Internet capabilities. On a quarterly basis, staff consults with leading payers on their current provider Internet options and uses this information in updating its Payer Internet Guide. The Payer Internet Guide was developed in August 2004 by staff with the assistance of the Workgroup. Information contained in the guide reports on the capabilities of six major payers in Maryland. The updated version will be posted on the MHCC Web site in April.

Figure 1 presents download trends of the existing Payer Internet Guide and the Practice Management Software (PMS) Self-Evaluation Tool from June 2004 through March 2005.



Staff continued to work with Maryland payers that offer a dental product to develop a Dental EDI Fact Guide. The Dental EDI Fact Guide contains information on payers' ability to electronically accept the HIPAA (Health Insurance Portability and Accountability Act of 1996) administrative transactions. Staff will use this information to work with the Maryland State Dental Association and the Maryland Academy of General Dentistry to increase EDI activity among dentists. Dental EDI has historically trailed other health care providers. Staff is in the planning stages of a dental EDI education and awareness workshop for early fall.

EHN Certification

Last month staff provided assistance to Health Fusion, an electronic health network (EHN) interested in obtaining MHCC-certification. Staff also provided consultative services to Health Data Exchange in completing its application for MHCC recertification. Staff continues to be successful in its efforts to increase the number of MHCC certified EHNs. As of the end of March, eighteen EHNs are MHCC certified with two additional EHNs in MHCC candidacy status. During the month staff provided support to three EHNs interested in entering the Maryland market.

HIPAA Awareness

MHCC's HIPAA education and awareness initiatives continued throughout March. Over the last month, staff received approximately twenty-five telephone inquiries from payers and providers requesting support information on HIPAA. During the month, staff provided support to the following organizations:

- Maryland Chiropractic Association
- EPIC Pharmacies
- Montgomery County Medical Association
- Maryland State Ambulatory Association
- Southern Maryland Hospital
- St. Joseph Hospital
- Maryland State Dental Association
- Sheppard Pratt Hospital
- Maryland State Podiatric Association

E-Scripting Initiative

Staff provided support to EHNAC in finalizing its E-Script Network Accreditation criteria. EHNAC's public comment period ended on March 28th. Generally speaking, EHNAC's E-Script Network Accreditation criteria received favorable comments from the industry. EHNAC recently announced that it will begin accepting applications from pharmacy EHNs in September. SureScripts and RxHub, two leading pharmacy EHNs, have expressed an interest in seeking EHNAC accreditation. Staff expects these two EHNs to seek EHNAC accreditation and MHCC-certification under the new accreditation program in early fall.

PERFORMANCE AND BENEFITS

Benefits and Analysis

Small Group Market

Comprehensive Standard Health Benefit Plan (CSHBP)

On January 31, 2005, Commission staff mailed the survey material to all carriers participating in the small group market in Maryland to collect their annual financial data. The deadline for carriers to submit these data was April 1st. All surveys were submitted timely. Staff is in the process of completing an analysis of the survey results, including number of lives covered, number of employer groups purchasing the CSHBP, loss ratios, average premiums as they relate to the ten-percent affordability cap, etc. Staff will present these findings to the Commission at the May meeting.

Limited Benefit Plan (LBP)

In 2004, the Maryland General Assembly enacted SB 570, requiring the Commission to develop a Limited Benefit Plan (LBP) that will be available to certain small employers beginning July 1, 2005. Along with holding meetings with interested parties and a public hearing, staff worked with Mercer, its consulting actuary, as well as CareFirst and MAMSI, to develop alternative proposals that meet the statutory requirement of pricing the LBP at 70% of the cost of the CSHBP as of January 1, 2004. The Commission approved the final regulations at the March meeting. The regulations will be implemented effective July 1, 2005.

Website

Commission staff have developed a website to be used as a guide for small business owners in their search for health insurance for their employees. This "Guide to Purchasing Health Insurance for Small Employers" is available on the Commission's website at: www.mhcc.state.md.us/smgrpmt/index.htm. Commission staff have developed a bookmark describing information available on the small group website. This bookmark has been distributed to various interested parties, such as small business associations, Chambers of Commerce, the Maryland legislature, the Department of Labor, Licensing and Regulation, and the Department of Business and Economic Development. As a result of the initial mailing, many of these organizations have requested additional bookmarks to distribute to their constituents.

Health Savings Accounts

In December 2003, Congress passed the Medicare Prescription Drug, Improvement and Modernization Act, authorizing the offering of health savings accounts (HSAs) in conjunction with high deductible health plans. These plans became available to small employers in Maryland effective July 1, 2004 if carriers elect to develop and market them. The CSHBP regulations have been modified to accommodate this offering during the transition period (for contracts sold between July 1, 2004 and December 31, 2004) and may have to be further modified to accommodate additional federal guidelines in the future. Aetna began offering an HSA-compatible PPO product in Maryland's small group market in August 2004.

The National Association of Health Underwriters has added a new section to its website entitled, "Understanding Health Savings Accounts." The link also has been linked to the above-mentioned Commission website for small businesses. (<http://www.nahu.org/consumer/HSAGuide.htm>)

Evaluation of Mandated Health Insurance Services (2004)

Pursuant to the provisions of §15-1501(f)(2) of the Insurance Article, *Annotated Code of Maryland*, Commission staff requested that members of the House Health and Government Operations (HGO) and Senate Finance Committees submit proposals for mandated health insurance services that they would like included in the annual evaluation. As required under current law, the Commission must evaluate all mandates enacted or proposed by the General Assembly and new suggestions submitted by a member of the General Assembly by July 1st of each year. For the 2004 report, three requests for mandate evaluation were submitted by members of the General Assembly: to evaluate wraparound mental health services for children; to evaluate air ambulance services; and to evaluate smoking cessation coverage. The 2004 final report was submitted to the 2005 Maryland General Assembly and is available on the Commission's website. The HGO and Senate Finance Committees were briefed on this report in January.

Legislative and Special Projects

Uninsured Project

DHMH, in collaboration with the MHCC and the Johns Hopkins School of Public Health, was awarded a \$1.2 million State Planning Grant by the Health Resources and Services Administration (HRSA). HRSA is the federal agency that oversees programs to ensure access to care and improve quality of care for vulnerable populations. The one-year federal grant provides Maryland with substantial resources to examine the state's uninsured population and employer-based insurance market and to develop new models to make comprehensive health insurance coverage fully accessible to all Maryland residents.

Among the several activities, the grant has enabled DHMH and MHCC to conduct further analysis of existing quantitative data sources (Maryland Health Insurance Coverage Survey, MEPS-IC, and CPS), as well as collect additional data to help design more effective expansion options for specific target groups. In addition, focus groups with employers were conducted in order to better understand the characteristics of firms not currently participating in the state's small group market. A report summarizing the findings from the focus groups is available through a link on the Commission's website.

The grant team was awarded a one-year, no cost extension of the project timeline, with an interim report submitted to the Secretary of the Department of Health and Human Services (HHS) in November. DHMH has applied for another one-year, no cost extension to extend the grant activities to August 2005. During this period, DHMH will conduct a telephone survey of Medicaid recipients to clarify the discrepancy in data between the number of Medicaid enrollees listed in DHMH's administrative data and the number of Maryland Medicaid enrollees reported in the Census Bureau's Current Population Survey (CPS). MHCC staff is providing technical assistance. In addition to the Medicaid analysis, the remaining funding through the grant will be used for projects approved by the HRSA SPG administrative staff, such as (1) development of an outreach strategy for its Primary Care Waiver once it is approved by the Centers for Medicare and Medicaid Services (CMS); (2) provision of funding for the analysis of the Maryland data from the Medical Expenditure Panel Survey – Insurance Coverage (MEPS-IC), as well as the layout design and printing of the report (Note: MHCC is taking the lead in overseeing this project); (3) provision of funding for modeling fiscal and other impacts of a statutory requirement that high-income individuals who do not purchase health insurance be subject to an income tax penalty; and (4) funding for an update to the Interim Report to HRSA and the Final Report due to HRSA in August 2005. The grant's supplemental funds that remain from the previous year total

approximately \$100,000 and are under the purview of the Department of Health and Mental Hygiene (DHMH), not the Maryland Health Care Commission.

The final report is due to HHS at the end of the contract period. The final report must outline an action plan to continue improving access to insurance coverage in Maryland. A report outlining the options to expand coverage to Maryland's uninsured was delivered to the members of Maryland's General Assembly in February 2004.

Patient Safety

Chapter 318 (HB 1274) of 2001 requires the Commission, in consultation with DHMH, to study the feasibility of developing a system for reducing preventable adverse medical events. A Maryland Patient Safety Coalition was initiated by the Delmarva Foundation and served as the Commission's sounding board for its activities related to patient safety. Three workgroups were formed: one to look at issues related to systems changes to be recommended; one to address current regulatory oversight and reporting requirements; and a third to discuss issues related to a proposed Patient Safety Center.

Commission staff released a request for proposal (RFP) to designate the Maryland Patient Safety Center (MPSC). The Maryland Hospital Association and the Delmarva Foundation have been selected to jointly develop and operate the MPSC. Both organizations have agreed to fund the Center for the first three years. The Health Services Cost Review Commission recently approved funding the MPSC during its first year (\$762,500) through increased hospital rates. This amount is equivalent to 50% of the anticipated Center expenses, and will be used in conjunction with funding from the MHA, Delmarva, and Maryland hospitals. A press conference announcing the designation was held on June 18, 2004 in Annapolis. Under the terms of the agreement, the Delmarva Foundation and the Maryland Hospital Association are required to submit semi-annual reports updating the status and progress of the MPSC. The first report was delivered to the Commission staff in November and provided to the Commissioners at the last Commission meeting. This report provides information on the MPSC's activities to date, including the arrangement of the governing structure and the staff; the formation of the advisory board, the recruitment of hospitals and nursing homes; data collection and analysis; and education (e.g., collaboratives).

Study of the Affordability of Health Insurance in Maryland

The 2004 General Assembly enacted SB 131/HB 845, requiring the Commission and the Maryland Insurance Administration to conduct a study of the affordability of private health insurance in Maryland. An interim report, including findings and recommendations from the study, was mailed to the Commissioners. At the January 11, 2005 Commission meeting (via conference call) the Commission approved the interim report for submission to the Maryland General Assembly. Copies of the report were distributed to the Senate Finance Committee and the House Health and Government Operations (HGO) Committee at briefings on January 25th and January 26th, respectively. The interim report also is posted on the Commission website. The final report is due by January 1, 2006. The HGO and Finance Committees were briefed on the Affordability study at the end of January.

2005 Legislative Session

The 2005 Maryland General Assembly session commenced January 12 and adjourned April 11, 2005. MHCC staff briefed the House Health and Government Operations Committee and the Senate Finance Committee on the Commission reports related to the small group market, mandated benefits, the report on Health Insurance Coverage in Maryland, the State Health Care

Expenditures report, and the Interim Report on the Study of the Affordability of Health Insurance in Maryland (SB 131/HB 845).

Facility Quality and Performance

Nursing Home Report Card

Chapter 382 (SB 740) of 1999 requires the Commission, in consultation with the Department of Health and Mental Hygiene and the Department of Aging, to develop a system to comparatively evaluate the quality of care and performance of nursing facilities. The web-based Nursing Home Performance Evaluation Guide is available through the Commission's website. The Guide includes a Deficiency Information page, data from the Minimum Data Set (MDS) and the MHCC Long Term Care Survey, as well as an advanced search capability, allowing consumers to search by facility characteristics and certain services.

In addition to indicators selected by the Maryland Nursing Home Performance Evaluation Guide Steering Committee, the site also includes the quality measures that are reported on the CMS Nursing Home Compare Website. Inclusion of this information on the Maryland site provides consumers with the ability to obtain comprehensive information in one location. The CMS measures were enhanced in January 2004 and are now consistent with the consensus recommendations from the National Quality Forum. The fourteen enhanced quality measures build on the original ten measures and provide additional information to help consumers make informed decisions.

Evaluation of the Nursing Home Guide

The Commission contracted with the Lewin Group to perform an evaluation of the nursing home performance evaluation guide. The purpose of this procurement was to conduct interviews with consumers and discharge planners to test the Guide in real-time with respondents using computers. The objectives of the study included: (1) evaluating consumer/professional usage, preferences, and understanding of the Guide; (2) determining ease in navigating through the website; (3) developing recommendations to improve the Guide; and (4) recommending outreach strategies to increase the utilization of the Guide.

All interviews were and a draft report was presented to the Nursing Home Performance Evaluation Guide Steering Committee for review and comment. The Lewin Group presented the final report to the Commissioners. The Nursing Home Report Card Steering Committee is in the process of prioritizing the recommendations.

Nursing Home Patient Satisfaction Survey

The Commission also contracted for the development of a nursing home patient satisfaction survey or the recommendation of an existing tool that provides information for consumers that can be integrated into the Maryland Nursing Home Performance Evaluation Guide by: (a) reviewing and summarizing existing nursing home satisfaction surveys and implementation processes developed by the federal government, state agencies, other public organizations and private entities or organizations; (b) discussing the cost of administration for each approach; (c) identifying the strengths and weaknesses of the various approaches and indicating whether a similar approach is feasible in Maryland; (d) designing or modifying a survey tool; and (e) proposing a plan for administering the tool including estimated implementation costs and timelines.

A report that included a review of the literature and interviews with various states was presented to the Nursing Home Report Card Steering Committee at its January 2004 meeting for review and comment. The Nursing Home Performance Evaluation Guide Steering Committee met on March 26, 2004 and recommended that we proceed with the self-administered family satisfaction survey and also pursue a pilot project in collaboration with AHRQ to pilot the Nursing CAHPS tool for resident satisfaction.

The RFP for the family satisfaction survey was released on November 1, 2004. The deadline for receipt of proposals was extended to December 8, 2004. The Evaluation Committee has reviewed all documents and requested best and final offers. The selected proposal will be taken to the Board of Public Works for final approval in April.

Nursing Home Patient Safety

The Steering Committee began discussion of nursing home patient safety measures that are appropriate for public reporting. The Committee was presented with an overview of the literature and activities and other states as well as a list of ten common patient safety measures. The Steering Committee agreed that we should begin with reporting health care facility-acquired infections and staffing as two indicators of safety.

Hospital Report Card

Chapter 657 (HB 705) of 1999 requires the Commission to develop a performance report on hospitals. The required progress report was forwarded to the General Assembly. The Commission also contracted with the Delmarva Foundation, in partnership with Abt Associates, to: (1) analyze hospital data to develop appropriate indicators for inclusion in the Hospital Performance Evaluation Guide, and (2) design and execute a consumer-oriented website for the Guide. The initial version of the Hospital Performance Evaluation Guide was unveiled on January 31, 2002.

The latest edition to the Hospital Guide features the addition of six new acute myocardial infarction (AMI) treatment measures. Additionally, trend information for the past two years were publicly reported for the first time. This latest version of the guide marks an important step in providing information on differences emerging in hospital practices and identifies a trend that, in general, shows hospitals' quality measures have improved. For instance, the provision of appropriate smoking cessation counseling for heart failure patients rose from 45 percent in 2002 to 81 percent in 2004. The number of people receiving appropriate discharge instructions for heart failure nearly doubled. The release also reveals that some hospitals have room for improvement. In the case of pneumonia care, many hospitals performed the recommended blood test more than 90 percent of the time while others perform the test less than 70 percent of the time. This edition of the Guide was released during a press event on January 27, prior to the Commission meeting.

The Guide also continues to feature structural (descriptive) information and the frequency, risk-adjusted length-of-stay, risk-adjusted readmissions rates for 33 high volume hospital procedures, and obstetrics data which were updated in December 2004 for admissions occurring during calendar year 2003.

Redesign and Expansion of the Hospital Guide

The Commission contracted with the Lewin Group to perform an evaluation of the hospital performance guide. The purpose of this procurement was to conduct interviews with consumers, primary care physicians, and emergency department physicians to test the Guide in real-time with respondents using computers. The objectives of the study included: (1) evaluating

consumer/professional usage, preferences, and understanding of the Guide; (2) determining ease in navigating through the website; (3) developing recommendations to improve the Guide; and (4) recommending outreach strategies to increase the utilization of the Guide.

All interviews were completed and a draft report was presented to the Hospital Performance Evaluation Guide Steering Committee for review and comment. The Lewin Group presented the final report to the Commissioners.

The Hospital Report Card Steering Committee met in July 2004 to begin the redesign process. During this meeting, the Committee approved four major areas of expansion- inclusion of composite measures and mortality data, use of different symbols and development of a hospital compare function.

The Committee met on October 12, 2004 at the University of Maryland in Baltimore County for a discussion of detailed redesign issues, facilitated by TechWrite, Inc., a subcontractor of Delmarva Foundation. The Committee agreed to a design that would specify portals for three major users- prospective patients, hospital leaders and hands-on providers. Understanding that each audience has different information requirements, the portals would serve as an entry point to targeted content, presentation and language. Website changes were prioritized and the redesign work is currently underway.

Patient Safety Public Reporting Workgroup

The goal of the Workgroup is to explore patient safety indicators that can be obtained from administrative data and then progress to other measures. The workgroup reconvened in October 2004. Staff presented preliminary AHRQ patient safety indicators and the workgroup recommended the availability for private viewing by hospitals while the Committee evaluates which indicators will be appropriate for public reporting. Staff will present preliminary mortality measures to the Hospital Guide Steering Committee at its next meeting.

Recommendations for publicly reporting healthcare acquired infections were made. The plan proposes to expand the Guide to include information on health care associated infections (HAI) – including both process and outcome measures. MHCC will work with the CDC, CMS, Patient Safety Center, and the Maryland Office of Epidemiology and Disease Control Programs on infection definitions, measurement and collection. The MHCC Commissioners approved the release of a call for public comments regarding the proposed HAI public reporting plan at its November 23rd meeting. The comment period ended December 7 with no comments precluding the data collection. However, facilities requested that a subset of the procedures be implemented initially to give hospitals the opportunity to gain experience with data collection and to ensure resource adequacy. Staff subsequently identified a subset of the measure which will be piloted with 2nd quarter data—knee arthroplasty, hip arthroplasty and colon surgery. Data collection using JCAHO specifications for the pilot measures began on April 1.

Additionally, the group has recommended that information regarding the availability of Intensivists in the ICU and progress toward computerized physician order entry (CPOE) be included on the Web site. The Committee realizes that there are varying definitions of CPOE and also realizes that some of the definitions may not be appropriate for use in the state at the current time; therefore, careful consideration will be given to components selected for reporting. Questions regarding Intensivists and CPOE were included with the hospital “Facility Profile Information” distributed near the end of October.

Staff will continue to work with the HSCRC, AHRQ, and others to produce data reports for committee review. Lastly, the workgroup recommended that the JCAHO patient safety measures be reported when they become available by either linking to the JCAHO report or adding the data to the Maryland Guide directly.

Staff attended the 1st Annual Maryland Patient Safety Center Conference on March 31st. Health care practitioners and leaders from around the state gathered to hear experts and explore better practices for improving patient safety in Maryland hospitals.

Patient Satisfaction Project

MHCC participated in a three-state hospital public reporting pilot project initiated by CMS. The Hospital Report Card Steering Committee served as the steering committee for the pilot. The Committee serves as the primary vehicle for obtaining input and consensus prior to initiating the state specific activities.

The Maryland Performance Evaluation Guide Steering Committee received a briefing on the pilot results during the January 27, 2004 meeting and agreed that Maryland should pursue the use of the tool to collect patient satisfaction data for the *Maryland Hospital Performance Evaluation Guide*. MHCC staff then met with representatives of CMS and AHRQ to discuss an additional pilot of the tool that will take place this summer. A proposal with a complete study design was submitted to AHRQ on April 6, 2004 to request permission to use the HCAHPS tool.

MHCC received approval to use the revised HCAHPS tool in another pilot that began in October 2004. MHCC received hospitals' submissions of four months of discharge data at the beginning of November 2004. Surveys were sent to the sample of patients drawn from the 47 acute care hospitals in Maryland. Pediatric and other specialty hospitals (e.g., cancer facilities) were excluded.

An average of 220 surveys per hospital were sent to the selected participants in an effort to obtain 100 completed surveys by mail or telephone. Discharges were classified as medical, surgical, or obstetrics services based on the DRG code. The surveys were randomly distributed across patients discharged from the hospital for medical, surgical, or obstetrics services (total=4,700 surveys for the state).

The survey process concluded in February 2005 and confidential results were shared with the hospitals. The hospital Guide Steering Committee will be briefed on the aggregate results at the end of the month and determine next steps in incorporation of satisfaction information in the guide.

Other Activities:

The Facility Quality and Performance Division is also participating in the planning process for a new Health Services Cost Review Commission (HSCRC) Quality Initiative designed to evaluate and recommend a system to provide hospitals with rewards and/or incentives for high quality care. Staff attends the HSCRC Quality Initiative Steering Committee meetings on an ongoing basis. The draft report of the HSCRC Steering Committee was also presented to the Hospital Performance Evaluation Guide Steering Committee on January 27, 2004 for review and comment. Since that time, HSCRC developed an implementation framework that was presented to the Commissioners during the January 2005 meeting.

Ambulatory Surgery Facility Report Card

Chapter 657 (HB 705) of 1999 also requires the Commission to develop a performance report for Ambulatory Surgery Facilities (ASF). The Commission developed a web-based report that was also released on May 16, 2003. The 2003 data have been added to the site.

The website contains structural (descriptive) facility information including the jurisdiction, accreditation status, and the number and type of procedures performed in the past year. It site also includes several consumer resources. The site is currently being updated to provide search and compare functionality, as well as show volume data over a three year period.

An ASF Steering Committee was convened to guide the development of the report and consists of representatives from a multi-specialty facility, a large single specialty facility, an office based facility, a hospital based facility, and a consumer representative. An exploratory meeting was held with a subset of this group in January 2003. Subsequently, the Steering Committee provided input on several of the proposed web pages including a consumer checklist, glossary, and list of resources. Staff continues to research recent developments in performance measurement in ambulatory surgery.

HMO Quality and Performance

Distribution of 2004 HMO Publications

Cumulative distribution: Publications released 9/27/04	9/27/04 to 3/31/05	
	Paper	Electronic Web
Measuring the Quality of Maryland HMOs and POS Plans: 2004 Consumer Guide (22,000 printed)	20,785	Visitor sessions = 2,020
2004 Comprehensive Performance Report: Commercial HMOs & Their POS Plans in Maryland (600 printed)	600	Visitor sessions = 998
Measuring the Quality of Maryland HMOs and POS Plans: 2004 State Employee Guide— 50,000 printed and distributed during open enrollment		

8th Annual Policy Issues Report (2004 Report Series) –

Released January 2005; distribution continued until January 2006

Maryland Commercial HMOs & POS Plans: Policy Issues (900 printed)	609	Visitor Sessions: 283
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Distribution of Publications

Paper distribution has experienced an upswing of twenty-six percent compared to this same period last year. With only a limited supply of *Consumer Guides* remaining, outreach efforts will soon shift to soliciting orders for fall distribution of the 2005 *Consumer Guide* and promoting use of the electronic HMO performance reports.

Last month staff obtained a list of the largest credit unions (ranked by assets) in the Baltimore area and contacted those that have at least twenty employees. Fifteen credit unions, that have over six hundred employees in total, met this threshold. Three of the credit unions requested copies for distribution or review for employee use during their May/June open enrollment. The majority of remaining credit unions have October/November open enrollment. Staff shipped sample copies of the 2004 *Consumer Guide* to their benefits administrators and will contact them again when the release of the 2005 edition will coincide with their open enrollment periods.

2004 Performance Reporting: HEDIS Audit and CAHPS Survey

HEDIS Audit Activities

Key audit functions continued during March. In preparation for onsite activities, auditors from HealthcareData.com (HDC), the audit contractor, and Division staff finalized a core set of measures. The core measurement set forms the foundation upon which HEDIS auditors investigate a plan's systems and processes for weaknesses. The key focus areas for the measurement sets emerged from a review of each plan's baseline assessment tool (BAT), a comprehensive tool that collects documentation of the effect that a plan's information management practices have on HEDIS reporting. MHCC staff has three objectives in reviewing the BAT: to determine the level of plan compliance in completing the BAT; to determine the degree of auditors' oversight in this mandatory part of the audit; and to determine if content of the BAT could contribute to any of the HMO publications. Staff efforts have successfully managed to bring plans into compliance with their 2005 HEDIS BAT submissions.

Site visits to six of the seven plans that will take part in MHCC's 2005 review of commercial managed care plans have been completed. A medical issue with a key participant in the audit process necessitated rescheduling the onsite assessment for Coventry Health Plan of Delaware.

To ensure a greater degree of confidence in the accuracy of rates reported to the Commission, requirements for the new HEDIS Audit Services contract stipulate several new validation procedures. Implementation of these new methods has been monitored by staff. Plans, auditors, and staff have encountered some challenges with the integration process. Although, guidance was given to the audit firm and plans before the audit season started to facilitate integration, the unique programming specifications of one method resulted in postponement until the next audit period. Lead auditors will use an alternative method developed by the audit firm and approved by this Division.

Recent discussions with HDC have resulted in a preliminary agreement allowing the use of NCQA developed programs (test decks) to validate programming code used by plans for data extraction. Tentative meetings have been set for late spring and early summer to finalize details and provide instructions to plans on software use.

Division staff will participate in onsite visits next month to Coventry and the managed behavioral health organizations providing these specialized services to their members.

Consumer Assessment of Health Plan Study (CAHPS Survey)

As a check on the survey process, HMO Division staff was seeded for each of the four scheduled mailings to sampled members from each plan. To date, all four mailings have been completed. The Myers Group (TMG), the CAHPS survey contractor, has been contacted regarding non-receipt of several pieces for which staff was seeded. A meeting has been scheduled for April to examine the mail protocol, tracking tools, and response rates for plans at the conclusion of the mail phase of survey administration.

At the end of April, telephone follow-up calls will begin to members of the sample group who have not yet completed a questionnaire. The phone portion of the survey includes six attempts to reach persons in the sample group.

Report Development Contract--Procurement

A request for proposals (RFP) for HMO Report Development work for the next contract period (2005 - 2007, with an extension period of one additional year through May 31, 2008) has been submitted to the Department of Budget and Management for approval. Comments have been received back and revisions made. Release of the RFP will occur once final approval has been granted.

HEALTH RESOURCES

Certificate of Need

Staff issued six determinations of non-coverage by Certificate of Need (CON) review during March. In licensure-related activities, determinations of non-coverage by CON review were issued to Edgemoade in Prince George's County to temporarily delicense 61 residential treatment center beds at the facility, and to Lorien Nursing and Rehabilitation Center-Columbia in Howard County to temporarily delicense 60 comprehensive care beds. Also, 31 CCF beds at Suburban Hospital and 21 CCF beds at Montgomery General Hospital, both in Montgomery County, which had been temporarily delicensed have been deemed abandoned by the Commission.

During the last month, Staff also issued a determination of non-coverage by CON review to Annapolis Surgery Center, LLC to establish an ambulatory surgery center with one operating room and one non-sterile procedure room to be located on Riva Road in Annapolis. Silver Spring Podiatry Center received a determination of non-coverage by CON review for a new site for its ambulatory surgery center with one operating room and one non-sterile procedure at a new site in Wheaton.

Acute and Ambulatory Care Services

Preparations are underway for the annual recalculation of the licensed bed designation for Maryland's acute general hospitals. These hospitals will again change their licensed acute care bed capacity as of July 1, 2005 for fiscal year 2006. Since 2000, Maryland law has required annual recalculation of all acute care hospitals' licensed capacity, based on their previous year's average daily census. Every hospital's licensed capacity is equal to 140% of its average daily census for the previous 12 month period ending March 31st. Within that number, hospitals are required to designate the number of beds for each acute care service. The resulting licensed bed capacity serves as the single, official source of acute care hospital bed inventory for the state. The forms that will be sent to the hospitals are being updated, and will be sent to the hospitals at the end of May with the new census data.

Holy Cross Hospital submits monthly reports to the Commission on the status of its construction project pursuant to the March 2004 approval of the modification to the hospital's Certificate of Need. The purpose of these reports is to advise the Commission about any potential changes to the terms of the modified CON, including changes in physical plant design, construction schedule, capital costs and financing mechanisms. The hospital's April 2005 update reports no changes to the project cost, the design or the financing of this project. The project is on schedule.

The last phase of the project, the addition of a new front to the hospital, is underway, and scheduled for completion in November of this year.

Long Term Care and Mental Health Services

Staff of the Long Term Care Division continues to represent the Commission at the Maryland Department of Aging's Continuing Care Advisory Committee. Staff is also attending the subcommittee meetings of this group that is involved with new issues. Issues surrounding continuing care retirement communities (CCRCs) being addressed include: notices to residents about changes in the scope of services; Medicaid participation rules; limitations on Certificate of Need-exempt CCRC beds; internal grievance procedures, and others. The subcommittee met on April 6, 2005 and the full committee is meeting on April 12, 2005.

The Maryland Hospice Survey 2004 has been available for data entry online since February 21, 2005. Since responses are due within sixty days, completed surveys are now being reviewed and reminder notices are being sent to those who did not request an extension of the timeframes. Survey data will continue to be monitored.

The Commission has had a standard in the State Health Plan since the 1980s requiring that facilities that participate in the Medicaid program serve their fair share of Medicaid patients. Recently the "fair share" has been defined as having an amount of Medicaid patient days as a proportion of total patient days that is at least equal to the jurisdiction or region, whichever is lower. This has resulted in a consistent proportion of Medicaid utilization in nursing homes, as reported in the Commission publication entitled: *Nursing Home Occupancy Rates and Utilization by Payment Source: Maryland, Fiscal Year 2002*.

This standard is implemented by requiring that the nursing homes sign a Memorandum of Understanding (MOU) with the Medicaid program as a condition of CON approval. Recently, the Medicaid program, using its own data along with data from the Commission, has sent letters to those facilities whose Medicaid proportions do not meet the standard in their MOU to require a plan of correction.

The Commission is in the process of updating the State Health Plan section for hospice services. This process involves a review of trends in hospice utilization, review of current need projection methodology, and a review of the current standards for Certificate of Need (CON) review of proposed hospice programs. During this review process, the Commission received a request from Erickson Retirement Communities proposing a revision to the hospice CON standards to permit a CCRC to submit a CON application to establish a specialty hospice that would solely serve residents of the CCRC, rather than contracting with existing hospices for services.

In order to address these issues, the Commission will be mailing out for public comment a draft of current standards and proposed revisions to the current CON standards for review of hospice services. This will be sent for public comment with responses due back in May.

Specialized Health Care Services

The Commission established the Primary PCI Data Work Group to develop recommendations related to the collection and reporting of data required by the State Health Plan for Cardiac Surgery and Percutaneous Coronary Intervention (PCI) Services (COMAR 10.24.17). Seven hospitals were selected to test a printed version of the data collection forms recommended by the Work Group: Holy Cross Hospital, Howard County General Hospital, North Arundel Hospital,

Sacred Heart Hospital, St. Agnes Hospital, Southern Maryland Hospital Center, and Washington Adventist Hospital. The Commission has received final feedback from four hospitals: North Arundel Hospital, St. Agnes Hospital, Sacred Heart Hospital, and Southern Maryland Hospital Center. The Commission's staff has contacted the remaining hospitals regarding their feedback. The Work Group will finalize its recommendations after reviewing the results of the pilot test. Staff has commenced work on a request for proposals to implement the Work Group's recommendations for a data coordinating center.

COMAR 10.24.17 requires that hospitals providing elective PCI services have cardiac surgical services on-site. This chapter of the State Health Plan also includes provisions for the Commission to consider a request for a waiver from its policies for a well-designed, peer-reviewed research proposal. On January 29, 2005, Thomas Aversano, MD sent to the Commission a proposal to study elective PCI at hospitals without on-site cardiac surgery. The Commission has appointed a Research Proposal Review Committee to review and provide advice on any research proposal that requires a waiver. Stephen J. Salamon, Chairman of the Commission, appointed Thomas J. Ryan, M.D. to chair the Committee. The Research Proposal Review Committee is scheduled to meet to consider the elective PCI proposal on Tuesday, April 19th, from 9:00 a.m. to 4:00 p.m. at the BWI Marriott, 1743 West Nursery Road, Baltimore, MD 21240. A continental breakfast will be provided for Committee members from 9:00 a.m. to 9:45 a.m.

The Commission collects quarterly survey data to examine current utilization and project future utilization of bone marrow and stem cell transplant programs in the Maryland and Washington regional service areas. The Maryland region consists of Baltimore City and the counties of Maryland, excluding Charles, Montgomery, and Prince George's; the Washington region includes those counties, plus Washington, D.C. and Northern Virginia. The submission of calendar year 2004 data by the program at George Washington University Hospital is still pending. Staff is continuing to follow up requests for submission of the hospital's data.